DESCRIPTION OF TAX PROPOSALS

RELATING TO

TAX CREDIT FOR CHILD CARE AND
CERTAIN HEALTH INSURANCE PREMIUMS,

SIMPLIFICATION OF SECTION 89 NONDISCRIMINATION
RULES APPLICABLE TO CERTAIN EMPLOYEE BENEFIT PLANS (S. 1129),

REPEAL OF SPECIAL RULES APPLICABLE TO
FINANCIALLY TROUBLED FINANCIAL INSTITUTIONS, AND

EXTENSION OF TELEPHONE EXCISE TAX

Scheduled for a Hearing

Before the

SENATE COMMITTEE ON FINANCE

On June 12, 1989

Prepared by the Staff

of the

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INTRODUCTION

The Senate Committee on Finance has scheduled a hearing on June 12, 1989, on tax proposals relating to (A) tax credit for child care and certain health insurance premiums; (B) simplification of section 89 nondiscrimination rules applicable to certain employee benefit plans (S. 1129, introduced by Senator Bentsen and others); (C) repeal of special rules applicable to financially troubled financial institutions; and (D) extension of the telephone excise tax.

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of present law and the tax proposals scheduled for the hearing.

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[1] This document may be cited as follows: Joint Committee on Taxation, Description of Tax Proposals Relating to Tax Credit for Child Care and Certain Health Insurance Premiums, Simplification of Section 89 Nondiscrimination Rules Applicable to Certain Employee Benefit Plans (S. 1129), Repeal of Special Rules Applicable to Financially Troubled Financial Institutions, and Extension of Telephone Excise Tax (JCX-13-89), June 9, 1989.

DESCRIPTION OF TAX PROPOSALS

A. Tax Credit for Child Care and Certain Health Insurance Premiums

Present Law

Child and dependent care credit

Under present law, an individual who maintains a household that includes one or more qualifying individuals is entitled to a nonrefundable tax credit equal to a percentage of the employment-related child or dependent care expenses paid by the individual for the taxable year to enable the individual to work (sec. 21). The maximum amount of the credit is 30 percent of allowable employment-related expenses. This 30 percent is reduced by one percentage point for each $2,000 (or fraction thereof) of the taxpayer's adjusted gross income (AGI) between $10,000 and $28,000. The credit rate is 20 percent for taxpayers with AGI in excess of $28,000.

The maximum amount of expenses that may be taken into account in calculating the credit is limited to $2,400 per year in the case of one qualifying individual and $4,800 in the case of more than one qualifying individual. In addition, the maximum amount of expenses taken into account cannot exceed the individual's earned income or, in the case of married taxpayers, the lesser of the individual's earned income or the earned income of his or her spouse. A special rule applies for determining the income of the taxpayer's spouse if the spouse is a full-time student or mentally or physically incapable of caring for himself or herself.

A "qualifying individual" is (1) a dependent of the taxpayer who is under the age of 13 and with respect to whom the taxpayer is entitled to claim a dependent exemption, (2) a dependent of the taxpayer who is physically or mentally incapable of caring for himself or herself, or (3) the spouse of the taxpayer, if the spouse is physically or mentally incapable of caring for himself or herself.

Tax provisions relating to individual health insurance

Present law generally does not provide tax benefits specifically designed to encourage the purchase of health insurance by individuals; however, present law does provide certain tax benefits for health insurance in particular circumstances.

Under present law, health insurance that is paid by an

individual's employer is generally excluded from an employee's gross income. This exclusion also applies for employment tax purposes. In addition, self-employed individuals are entitled to deduct 25 percent of the amount paid for medical insurance for the individual or his or her spouse or dependents; this provision is scheduled to expire for taxable years beginning after December 31, 1989. These provisions are subject to the application of nondiscrimination rules and certain other requirements.

Taxpayers who itemize deductions may deduct expenses for medical care (not compensated by insurance or otherwise) of the taxpayer or his or her spouse or dependents to the extent such expenses exceed 7.5 percent of the taxpayer's gross income. Premiums paid for health insurance qualify for the deduction.

Earned income tax credit

Amount of credit

The earned income tax credit (sec. 32) provides a refundable tax credit to taxpayers who maintain a household for a child. The credit is equal to 14 percent of the first $6,500 of earned income for taxable years beginning in 1989. Earned income generally includes wages and salary and self-employment income. The maximum credit allowable in 1989 is $910. For taxable years beginning in 1989, the credit is phased out at a rate of 10 percent of the amount of the taxpayer's AGI (or, if greater, the taxpayers earned income) that exceeds $10,240. The credit phases out completely at $19,340 or the greater of adjusted gross income or earned income. The $6,500 and $10,240 amounts are adjusted annually for inflation, so that the maximum credit amount and the maximum amount of income eligible for the credit also increase with inflation.

Eligibility for credit

The earned income credit is available to taxpayers who maintain a household for a child. The child generally must be under age 19 and must reside in the household for at least half the year. In general, the taxpayer must be entitled to claim the child as a dependent, and thus must provide over half of the support for the child. An exception is made in certain cases where a divorced head of household has custody but not the right to claim the dependency exemption. Married individuals must file a joint return in order to be eligible for the credit.

Refundability

Unlike most tax credits, the earned income credit is refundable; i.e., if the amount of the credit exceeds the

taxpayer's Federal income tax liability, the excess is payable to the taxpayer. If the individual does not claim the credit, the IRS can determine from the return that the individual may be eligible, and performs the credit calculation for the individual. This determination is made after review of the taxpayer's income, filing status, and dependency exemptions.

Under an advance payment system, eligible taxpayers may elect to receive the benefit of the credit in their paychecks, rather than waiting to claim a refund on their return filed the following year. Employers make payments to the employee during the year and receive credit for the payments against the employer's tax liability.

Explanation of Proposal

The proposal would make the present-law dependent care credit refundable and would allow an additional credit for expenditures for certain health insurance policies.

Refundable dependent care credit

The proposal would make the present-law dependent care credit refundable. That is, taxpayers who do not have sufficient taxable income to offset the credit would be entitled to receive the amount of the credit not offset against tax liability in cash.

Health insurance credit

The proposal would amend the dependent care credit to add a new refundable credit for health insurance expenses. The proposal would provide that an individual who maintains a household containing one or more qualifying individuals is entitled to a credit equal to a percentage of the individual's qualified health insurance expenses. The maximum credit percentage is 50 percent of the qualified health insurance expenses. This 50 percent is reduced by 5 percentage points for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income (AGI) exceeds $12,000. Thus, the credit is zero for taxpayers with AGI in excess of $21,000.

Qualified health insurance expenses are amounts paid during the taxable year for health insurance that includes coverage for one or more qualifying individuals. For purposes of this credit, a qualifying individual is a dependent of the taxpayer who is under age 19 and with respect to whom the taxpayer can claim a dependent exemption.

Up to $1,000 of qualified health insurance expenses may be taken into account in calculating the credit. However, the maximum expenses taken into account cannot

exceed the earned income of the taxpayer, reduced by employment-related expenses taken into account in determining the child care credit. Expenses, to the extent paid, reimbursed, or subsidized by the Federal government or a State or local government, are not eligible for the credit.

Eligible taxpayers may claim both the dependent care credit and the health insurance credit.

Child health demonstration projects

The proposal authorizes the appropriation of $25 million for each of the fiscal years 1990 through 1994 to enable the Secretary of Health and Human Services to conduct demonstration projects to evaluate and extend health insurance to children under age 19 who are not covered by other public or private health programs.

The Secretary is authorized to enter into agreements with public and private organizations (for example, schools and hospitals) to provide health insurance coverage to such children. The Federal government is to share up to 50 percent of the cost of programs under such agreements.

The health care program provided by an organization pursuant to such an agreement cannot restrict enrollment on the basis of a child's medical condition or impose waiting periods or exclusions for preexisting conditions. The program can also cover the parents of the child . The Secretary may permit the organization to charge for the health care.

The Secretary is directed to publish by January 1, 1990, criteria governing the eligibility and participation of organizations in the demonstration projects.

Effective dates

The refundability feature of the present-law dependent care credit would be effective with respect to taxable years beginning after December 31, 1989. The health insurance credit would be effective for taxable years beginning after December 31, 1990.

Possible Options Under the Proposal

Option 1

For years beginning after December 31, 1991, both the present-law dependent care credit and the health insurance credit could be refundable on an advance basis.

Option 2

The Secretary of the Treasury could be directed to study the feasibility of permitting advance payments of the dependent care credit and the health insurance credit in a manner similar to the advance payment system under the earned income tax credit.

Description of President's Proposal

Proposed child tax credit

Under the President's budget proposal, low-income families with at least one working individual would be entitled to claim a new refundable tax credit of up to $1,000 for each dependent child under age four. For each child under the age of four, families could claim a credit equal to 14 percent of earned income, with a maximum credit equal to $1,000 per child. Initially, the credit would be reduced by an amount equal to (1) 20 percent times the number of such children multiplied by (2) the excess of the greater of (a) AGI or (b) earned income over $8,000. The credit would not be available to families with AGI or earned income greater than $13,000. In subsequent years, both the starting and end-points of the phaseout range would be increased by $1,000 increments. In 1994 and subsequent years, the credit would phaseout between $15,000 and $20,000.

Families would have the option of receiving the tax benefit through an advance payment system similar to the earned income tax credit.

Refundable child and dependent care credit

The existing child and dependent care tax credit would be made refundable. Families could not claim both the new child care credit and the child and dependent care credit with respect to the same child, but could choose the larger of the two credits.

Effective date

The provisions would be effective for taxable years beginning after December 31, 1989.

Description of S. 412[2]

The bill would retain the present law child care tax credit with three modifications. First, expenses relating to dependent children under age 13 would be eligible for a higher credit percentage and a different phasedown range than other eligible expenses. The applicable percentage of the expenses that would be eligible for the credit would be 40 percent rather than 30 percent as allowed under present law. The applicable percentage would be reduced by 3 percentage points for each $2,500 of AGI in excess of $12,500.

For taxpayers with AGI in excess of $27,500, the credit rate would be 20 percent. The maximum credit amount for such expenses would be $960 for one dependent child under the age of 13 ($1,920 for two or more qualifying dependents).

Second, under the bill, the credit attributable to expenses described above relating to dependent children under the age of 13 would be made refundable for taxpayers with AGI not in excess of $27,500. A taxpayer could receive the benefit of the credit throughout the year through an advance payment system.

Finally, the bill provides that child care expenses reimbursed or subsidized by the Federal Government through other programs (e.g., Title XX and AFDC recipients), would not be eligible for the child care credit.

The bill also would provide for an increase in the present law Social Services Block Grant Program also, and would require the Administration to report on the Program to the Committee on Finance and the Committee on Ways and Means not later than 3 years after the date of enactment.

The bill would be effective for taxable years beginning after December 31, 1989.

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[2] Introduced by Senators Packwood, Moynihan and others on February 9, 1989.

B. Simplification of Section 89 Nondiscrimination Rules Applicable to Certain Employee Benefit Plans (S. 1129)[3]

Present Law

In general

Under present law, the nondiscrimination rules contained in section 89 apply to certain types of fringe benefit plans, including employer-provided health plans. There are two different ways of testing for nondiscrimination: a 4-part test and a 2-part test. An employer is not required to test under both methods. The employer elects which method to apply.

Four requirements must be met under the 4-part test. First, at least half of the employees eligible to participate in the plan must be rank and file employees. This test is designed to limit the tax-favored treatment of plans primarily covering highly compensated employees (e.g., executive-only plans).

The second requirement is that at least 90 percent of the rank and file employees must have available to them a benefit at least half as valuable as the most valuable benefit available to any highly compensated employee. This test is designed to ensure that a significant percentage of rank and file employees have a minimum benefit available to them. For example, if the highest benefit available to any highly compensated employee is worth $1,000, then to pass this test, 90 percent of the rank and file employees must have available a benefit of at least $500.

The third requirement is that the value of coverage received by rank and file employees must be at least 75 percent of the average value of coverage received by highly compensated employees. This test is designed to ensure that rank and file employees actually receive a significant portion of the tax benefits spent for health coverage.

Finally, under the 4-part test, the plan may not contain any provision relating to eligibility to participate that discriminates in favor of highly compensated employees (the nondiscriminatory provisions test). This is a subjective test and is intended to be applied in situations that are not

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[3] Introduced by Senators Bentsen, Pryor and others on June 6, 1989.

measured by the numerical tests, for example, where coverage for a rare disease is theoretically provided to all employees but in fact only the company president can benefit from the coverage. This test also applies to the method by which the employer tests.

Under the 2-part test, the following requirements must be satisfied. First, at least 80 percent of the employer's rank and file employees must be covered by the plan (or group of aggregated plans). This test was designed primarily for small employers.

The second requirement under the 2-part test is that the plan must satisfy the nondiscriminatory provisions test. This is the same test that is described above.

Special rules

Certain employees are disregarded in applying the nondiscrimination tests. In general, the employees that may be excluded are: (1) employees who normally work less than 17 1/2 hours per week (i.e., part-time employees), (2) employees who normally work less than 6 months during a year (i.e., seasonal employees), (3) employees under age 21, (4) employees who have not completed a minimum service requirement, and (5) nonresident aliens.

In general, employees who are covered under a plan of another employer (e.g., a spouse's plan) may be disregarded in applying the nondiscrimination tests. In addition, under special rules, family coverage may be tested separately from other coverage and only by taking into account those employees with families. Under these rules, an employer's plans will not fail the nondiscrimination tests simply because more highly compensated employees have families than do rank and file employees.

Under the rules relating to testing for nondiscrimination, a highly compensated employee is defined as an employee who during the year or the preceding year (1) was a 5 percent owner of the employer, (2) received compensation in excess of $81,720, (3) is an officer of the employer, or (4) received compensation in excess of $54,480 and was in the top paid 20 percent of employees. The dollar limits are indexed annually for inflation. In lieu of calculating the top-paid 20 percent of employees, the employer may elect to treat employees with compensation in excess of $54,480 as highly compensated employees.

In addition to the nondiscrimination rules, section 89 contains minimum requirements for health plans (and certain other types of plans). These rules require that a plan must be in writing, legally enforceable, maintained for the exclusive benefit of employees, intended to be maintained

indefinitely, and that employees be given reasonable notification of plan terms.

Explanation of the Bill

In general

Under the bill, new section 89 nondiscrimination rules and modified qualification rules are delayed for one year and are effective for plan years beginning after December 31, 1989. Prior to that date, the nondiscrimination rules under section 105(h) as in existed immediately prior to the passage of the Tax Reform Act of 1986 apply to certain self-insured health plans. See the discussion of the effective date below with respect to certain transition rules.

Eligibility test

The bill replaces the current section 89 nondiscrimination rules for health plans with a single test (the "eligibility" test). In general, an employer's health plan passes section 89 if the plan is not discriminatory on its face and at least one plan or a group of plans providing primarily core health coverage is available to at least 90 percent of the employer's employees at an employee cost to employees of no more than 40 percent of the total cost of the plan in the case of individual coverage, or 40 percent of the total cost of the plan in the case of family coverage (including coverage for the employee).

Under the bill, the eligibility test is satisfied if the plan is not discriminatory on its face and core (or primarily core) health coverage is available to 90 percent of the employees of the employer. This 90-percent test may be met by looking at all plans maintained by the employer that provide health coverage and that meet certain limits on the amount that may be charged to an employee for coverage. A plan that can be taken into account in applying the 90-percent test is called a qualified core health plan. This test does not require that the employer only offer health plans meeting the employee contribution requirements. Rather, the employer can offer a full array of plans as long as the availability test is met by at least one (or a group of) plans. If the employer fails to meet this new eligibility test, then the value of all health coverage provided to highly compensated employees is includible in the taxable income of the highly compensated employees.

The eligibility test under the bill does not require that a particular level of coverage be provided to employees. Instead, in order for all or a portion of the coverage provided to highly compensated employees to be provided on a tax-favored basis, some health coverage must be available to

a broad segment of employees. By using a requirement that limits the percentage of the total cost that may be required of an employee, the bill ensures that the employer subsidizes a portion of core health coverage, while also providing the employer flexibility in those instances where the cost of coverage varies because of geographic locale.

As under present law, the bill generally defines core health coverage as coverage for comprehensive major medical and hospitalization benefits. Core health coverage generally does not include coverage under dental, vision, disability, and accidental death and dismemberment plans. Flexible spending arrangements are not core health plans nor can such plans be a part of a qualified core health plan.

In determining what plans may be considered available for purposes of the eligibility test, the bill limits the percentage of the total cost of a plan that the employer may require an employee to pay. For individual coverage, the mandatory employee contribution cannot exceed 40 percent of the total cost of the plan generally determined under the health care continuation rules. For family coverage, the mandatory employee contribution cannot exceed 40 percent of the total cost determined in the same manner. Under the bill, this 40 percent limitation applies to family coverage that includes coverage for the employee. Thus, to the extent that a plan providing individual coverage requires a lower employer premium than the maximum level of employee premium under the bill, the additional employer subsidy under such plan may be used to help the employer meet the maximum employee premium requirements for a family plan. However, if the employer does not provide individual coverage meeting the employee contribution requirements under the bill, the employer does not meet the eligibility test. This is the case without regard to whether the employer maintains a family plan that meets the maximum employee premium requirements.

As under present law, the bill provides that the employer-provided coverage under a plan may be excluded from the taxable income of a highly compensated employee only if the plan does not contain any provision that (by its terms, operation, or otherwise) discriminates in favor of highly compensated employees. The purpose of the nondiscriminatory provision requirement is to preclude executive-only plans and other inherently discriminatory practices. As under present law, the requirement applies to the method and circumstances under which an employer determines whether it meets the requirements of section 89. For example, the requirement applies to the designation of a testing date.

The following examples illustrate the eligibility test.

Example 1.--An employer maintains several health plans

for its employees. Among these plans is a plan that provides core health coverage that is available to all employees. The plan has a total premium cost of $1,000 for employee-only coverage and requires an employee contribution of $250. This plan is a qualified core health plan and the employer meets this eligibility test without regard to the characteristics or employee contribution requirements of the other plans maintained by the employer.

Example 2.--An employer maintains two plans providing core health coverage. One plan is an indemnity plan and is available to employees at a cost of $200 per year for employee-only coverage (total annual premium cost of $1,200) or at a cost of $700 per year for family coverage (total annual premium cost of $2,000). This plan is available to 40 percent of the employees of the employer. The other plan is an HMO requiring no employee contribution and is available to 70 percent of the employer's employees. When considered together, 90 percent of the employer's employees are eligible for one or both of the plans. Both plans are qualified core health plans and may be considered for the eligibility test because the cost to employees under both plans is within the mandatory contribution range and both plans primarily provide core health coverage. If 90 percent of the employees can participate in one of the two plans, then the employer meets the eligibility test.

Benefits test

The purpose of the benefits test contained in the bill is to ensure that highly compensated employees do not receive a disproportionately higher level of employer premium than the level of employer premium that is available to a broad group of employees. Under the bill, the maximum tax-favored benefit that a highly compensated employee may receive is generally 133 percent of the employer premium for the employee-only coverage that may be taken into account in applying the eligibility test. However, if a highly compensated employee elects a specific level of family coverage, and if the employer maintains a plan that provides family coverage that meets the requirements under the bill for the eligibility test, then the tax-favored premium is increased to 133 percent of the employer-paid family premium taken into account in applying the eligibility test. If the employer maintains more than one core health plan providing family coverage (e.g., employee plus one or employee plus two), then for purposes of determining the limitation on benefits, an employee electing a specific level of family core coverage may receive tax-favored coverage based upon the employer subsidy under that plan. If the plan that is elected is not a qualified core health plan or a part of such a plan that meets the eligibility test, then any qualified core health plan with a smaller employer-provided value that passes the eligibility test may be used to determine the

limitation on benefits under the benefits test.

A highly compensated employee is not treated as electing a family plan unless the employee has elected a core health plan providing family coverage (without regard to whether the plan elected meets the eligibility test). Thus, for example, an employee that elects only a flexible spending arrangement has not elected family coverage.

For purposes of the benefits test, an employer may aggregate certain plans in determining the employer-provided benefit available to 90 percent of the employees. Because these rules are permissive, an employer is not required to aggregate plans and may designate any smaller level of employer-provided benefit to be multiplied by 133 percent, as long as that benefit satisfies the 90-percent eligibility test. However, an employer is likely to use the highest level of employer-provided benefit that satisfies the eligibility test in calculating the benefit to be multiplied by 133 percent.

Under the aggregation rule, the employer may increase the level of benefit available to employees by aggregating two or more plans if such plans are available to the same group of employees and, when combined, such aggregated plans constitute a qualified core health plan (i.e., are primarily composed of an employer-provided benefit relating to core health coverage and continue to meet the maximum employee contribution limitation on an aggregate basis). As noted above, flexible spending arrangements cannot be part of a qualified core health plan.

For example, if a dental plan with an employer-provided benefit of $499 and a core health plan with an employer-provided benefit of $501 are available to the same employees and the two plans meet the maximum contribution limitation when considered together, then such plans may be treated as one qualified core health plan with an annual employer-provided benefit of $1,000. If 90 percent of the employees are eligible for this plan or for other qualified core health plans with at least the same employer-provided benefit, the benefits test would be met if no highly compensated employee received an employer-provided benefit in excess of $1,330 (133 percent of $1,000). Of course, for purposes of the aggregation rules, overlapping coverage under the plans may not be considered more than once in determining the employer-provided benefit under the combined plans.

For purposes of testing under the benefits test, the bill makes permanent the temporary valuation rule under present law. Thus, as under present law, the employer may use any actuarially reasonable valuation method. In addition, the employer may use the cost of the coverage as that cost is determined under the health care continuation

rules. The employer may also make reasonable adjustments to cost, for example, adjustments for differences in cost in different geographic areas.

Any employer-paid premium received by a highly compensated employee in excess of the level of employer-paid premium that meets the benefits requirement is includible in the taxable income of such employee. As under present law, in determining the amount that is actually in excess of the benefits limitation and thus includible in the taxable income of the high paid, only cost as determined under the health care continuation rules may be used, with limited adjustments.

The benefits test is illustrated by the following examples.

Example 1.--An employer maintains only two health plans: an indemnity plan and an HMO. Both plans are available at no cost to over 90 percent of the employees. An employee may choose either plan. Under this example, there can be no failure of the benefits test because the highly compensated employees can only receive an employer-paid premium equal in value to the employer-paid premium available to 90 percent of all employees.

Example 2.--An employer maintains two health plans: an indemnity plan providing core health coverage that is available to all employees, and a dental plan available only to 20 percent of employees (including both highly and nonhighly compensated employees). Neither plan requires employee contributions. The employer cost for the indemnity plan is $1,400 as determined under the health care continuation coverage rules. The cost for the dental plan is $500. Under the bill, if a highly compensated employee participates under both plans, then the taxable portion of the premium to such employee is $38 ($1,900 less (1.33 x $1,400)).

Example 3.--An employer maintains several health plans. Three plans are core health plans. Each core plan is available to over 90 percent of all employees. The employer cost of each of the three core plans is $500, $1,000 and $1,500 respectively. The maximum excludable benefit that may be received by any highly compensated employee is $1,995 ($1,500 x 1.33). Thus, any highly compensated employee would have taxable income to the extent that the employee receives over $1,995 in health coverage.

Example 4.--An employer maintains several health plans. Among these plans is a family core indemnity plan with a total premium cost of $2,500, and a required after-tax employee contribution of $1,100. The employer also maintains a family dental plan with a total premium cost of $600 and a

required after-tax employee contribution of $100. Assuming these plans are available to all employees and that the employer maintains an employee-only core health plan that meets the requirements of the eligibility test, a highly compensated employee electing family coverage under the described core health plan may exclude $2,527 in health benefits (1.33 x $1,900) because, when combined, these plans constitute a qualified core health plan. The employee contribution limitation is met because the total employee cost for the plans ($1,200) is less than 40 percent of the total cost for both plans ($3,100).

Example 5.--An employer maintains two core health plans. One plan is an employee-only plan with a total premium cost of $1,250 and a required after-tax employee contribution of $250 per year. The other core plan provides family coverage for the employee, and the employee's spouse and dependents. The employee pays the full cost of the plan. Assuming that the employee-only plan is available to 90 percent of the employees of the employer, a highly compensated employee may exclude $1,330 in coverage ($1,000 x 1.33) whether that employee enrolls in the family or individual plan.

Special rules for small employers

The bill provides several rules relating to small employers. First, the bill has created a design-based test. An employer can know at the time it offers its plans to its employees that it meets section 89. For example, an employer offering only one plan to 90 percent of its employees may pass the tests without further testing or data collection.

Second, the bill modifies several rules in the excludable employee area. Among these changes is a rule permitting an employer with 20 or fewer employees to disregard employees for purposes of the eligibility test who are determined to be uninsurable by reason of a medical condition by the insurance company that provides core health coverage to the employees of the employer. The insurance company's determination is to be based on its customary standards for insurability applied to groups of that size.

With respect to part-time employees, employers with 20 or fewer employees (including such part-time employees) may exclude part-time employees normally working less than 30 hours per week in 1990, 27.5 hours per week in 1991, and 25 hours per week thereafter.

The bill contains a rule designed to benefit small employers in determining the number of employees to whom coverage must be made available. Under the bill, in determining the number of employees who must be eligible for coverage under the eligibility test, an employer may round

down to the nearest number of employees. For example, if an employer has 11 employees, only 9 must have coverage available if the employer is to meet the eligibility test.

The bill clarifies that for testing under section 89, a small employer may use average premium cost even if the employer's premium is calculated on an individually rated basis.

Finally, for employers with 20 or fewer employees, the written plan requirement under the qualification rules may be satisfied by the insurance contract that is currently in effect relating to the coverage provided by the employer.

Part-time employees

Under the bill, employees who normally work less than 25 hours a week are disregarded for purposes of the nondiscrimination tests (compared with 17.5 hours under present law). In addition, the employee premium and the employer-provided coverage may be proportionately adjusted for less than full-time employees. Under this rule, the maximum employee contribution limitation is increased to 60 percent for employees normally working between 25 and 30 hours per week. Further, for purposes of the benefits test, such an employee is treated as contributing only 40 percent of the total cost of the plan despite the higher contribution level. This rule permits a part-time employee to be treated the same as a full-time employee, even though the part-time employee pays more for the same coverage and so receives a lower employer-paid benefit.

Leased employees

Under the bill, the present-law historically performed test is repealed and replaced with a new rule defining who must be considered a leased employee. This change is made because the proposed regulations under the leased employee rules (sec. 414(n)) are overly broad in defining who may be a leased employee. Under the bill, the proposed regulations are no longer valid to the extent they relate to the historically performed test under present law.

Under the bill, an individual will not be considered a leased employee unless the individual is under the control of the recipient organization. The bill clarifies present law in that support staff of professionals continue to be treated as leased employees (to the extent the are not common law employees).

Under the bill, persons who perform incidental services under certain arrangements are not leased employees. This rule does not extend to the operation (including supervision over such operation) of the goods, equipment, or completed

facility that is the subject of such arrangement.

Union employees

The bill provides that plans maintained pursuant to collective bargaining agreements are tested separately with respect to employees covered by the agreement. The separate testing rule applies on a bargaining unit by bargaining unit basis. In addition, multiemployer plans are generally exempted from the nondiscrimination rules of section 89. Finally, employees that are covered under the Davis-Bacon Act are excluded employees for purposes of the nondiscrimination rules.

Former employees

As under present law, the nondiscrimination tests are applied separately to former employees of the employer. The bill delays the application of section 89 to former employees for one year, to 1990. Further, employees who separate from service prior to 1990 are not considered for purposes of testing. In addition, the bill provides that in determining whether former employees meet the nondiscrimination requirements, the employer may consider only those employees that meet certain reasonable eligibility requirements relating to age or service. The Secretary is authorized to impose restrictions on instances where age or service requirements are not reasonable and may allow other eligibility criteria to be imposed by the employer.

In applying the nondiscrimination tests to former employees, the mandatory employee contribution limits do not apply. Thus, as long as 90 percent of the employees in a class of former employees being tested are eligible for a core health plan on the same terms, that plan may be a qualified core health plan without regard to whether it meets the limitation on employee contributions.

Excluded employees; individuals participating in certain government-sponsored programs

Under the bill, certain individuals are excluded for purposes of determining whether the employer meets the nondiscrimination tests. In addition to part-time employees, other individuals are excluded from testing. Excluded employees include employees with less than 6 months of service, seasonal employees, non-resident aliens, and students.

A series of new exclusions are added to the statute. These individuals include senior citizens employed pursuant to Title V of the Older Americans Act or under the Environmental Programs Assistance Act of 1984. Students under certain programs qualified under Title VIII of the

Higher Education Act of 1965, and certain disabled individuals are also excluded employees. Finally, inmates in state, local, or Federal correctional facilities are excluded employees. The Secretary is authorized to designate certain additional classes of individuals as excluded employees if treatment of such individuals as employees is inappropriate in light of the policy purpose underlying the Federal or state program authorizing or encouraging such participation and the nondiscrimination rules. This rule excluding certain individuals is not intended to create any inference with regard to the appropriate treatment of such individuals as employees under other provisions of the Code.

Under present law, if the employer provides coverage to an otherwise excluded employee, the employer may test all excluded employees of that class separately from other employees. The bill modifies this rule and allows the employer to disregard excluded employees that receive coverage. A similar rule applies to all classes of excluded employees, except those employees that are excluded because they have not yet met the 6 month service requirement. Present law (including regulations) continues to apply to these employees.

Definition of highly compensated employee

The bill amends the definition of who constitutes a highly compensated employee for purposes of section 89. Under present law, officers with compensation over $45,000 (indexed) are highly compensated employees. However, an employer will always have at least one highly compensated officer regardless of that officer's compensation. Under the bill, only officers with compensation in excess of the $50,000 limitation (indexed to $54,480 for 1989) that is otherwise applicable for determining who are highly compensated employees must be considered highly compensated employees. This rule will benefit employers who, but for the present-law rule, would have no highly compensated employees. These employers include many municipalities and tax-exempt organizations.

In addition, the bill requires that beginning in 1990, the compensation levels specified in the definition of highly compensated employee will be rounded to the nearest $1,000.

Cafeteria plans

The bill provides special rules for the treatment of salary reduction contributions. For purposes of the eligibility test, the general rule is that salary reduction contributions are employee contributions. Thus, a plan does not meet the eligibility test to the extent that such contributions (and other employee contributions) exceed the 40-percent limitation on employee contributions.

For purposes of both the eligibility and benefits tests, certain salary reduction contributions are treated as an employer-provided benefit. These salary reduction amounts are those that are available to the employee only to the extent that: (1) the employee indicates to the employer that he or she has core health coverage elsewhere, either through another employer or the employer of a spouse or dependent; (2) the employee does not elect any c re health plan maintained by the employer; and (3) such amount is available in cash to the employee. These salary reduction amounts are considered employer-provided in determining whether the plan meets the eligibility test. They are also treated as employer-provided in determining the employer-provided portion of the qualified core health plan that is multiplied by 1.33 to determine the benefits limitation under the benefits test (but only to the extent that such amounts relate to the plan in question).

In determining the employer-provided portion of the qualified core health plan that is multiplied by 1.33 to determine the benefits limitation under the benefits test, certain salary reduction amounts other than those amounts described in the preceding paragraph may also be considered (to the extent that such amounts relate to the plan in question). These additional salary reduction contributions are treated as employer-provided to the extent they do not exceed the employer-provided premium relating to such plan, excluding all salary reduction contributions.

For purposes of determining the employer-provided coverage provided to the highly compensated employees, all salary reduction contributions are considered employer-provided.

The treatment of salary reduction contributions under the bill is illustrated by the following example. A plan has a total cost of $1,500 and a required employee contribution of $400, paid through a salary reduction agreement. Under the plan, if an employee has other core health coverage and elects no core health coverage, the employer will pay the employee $300. Thus, there are $700 of salary reduction contributions under the plan. Assuming that this plan is available to 90 percent of the employees, the plan will meet the eligibility test. This is because the required employee contributions ($400) are less than 40 percent of the total cost of the plan ($1,500). The employer-provided portion of the plan for purposes of multiplying by 1.33 under the benefits test is $1,500. This amount is composed of the $800 of employer-provided contributions (excluding salary reduction), $300 of salary reduction that is given preferential treatment under the special rule described above, and the remaining salary reduction under the plan ($400). The $400 is treated as employer-provided because it does not exceed the $800 in nonsalary reduction under the

plan. Thus, the benefits limitation for the highly compensated employees is $1,995 ($1,500 x 1.33).

Group-term life insurance

Under present law, group-term life insurance plans are subject to the section 89 nondiscrimination rules. To further simplify section 89, the bill provides that the nondiscrimination rules in effect prior to the Tax Reform Act of 1986 (with certain modifications) apply to group-term life insurance for years beginning in 1989 (sec. 79(d)).

For years beginning after December 31, 1989, the bill makes certain conforming changes to the pre-Tax Reform Act rules to take into account changes in the law. First, the rules are modified in order to compare highly and nonhighly compensated employees rather than key employees and all other employees. Second, section 79 will include the Tax Reform Act rule that group-term life insurance is discriminatory to the extent it takes into account compensation in excess of $200,000 in determining a multiple of compensation benefit under a plan.

Under the bill, accidental death and dismemberment plans (AD&D) are treated as group-term life insurance plans solely for purposes of nondiscrimination testing. Thus, a death benefit under an AD&D plan that is based on a uniform multiple of compensation (not in excess of the $200,000 limitation) is not discriminatory solely because of the use of such multiple.

Dependent care assistance programs

Under the bill, section 89 does not apply to dependent care assistance programs. For plan years beginning in 1989, the nondiscrimination rules under section 129(d) are applicable to such plans and are modified in two respects. First, if a plan fails to meet the requirements of section 129(d), only highly compensated employees must include benefits under the program in gross income. Second, if a dependent care assistance program fails the 55-percent benefits test contained in section 129(d)(7), then the highly compensated employee must include in gross income only that amount of benefit in excess of that level of benefit that would meet the benefits test.

Election not to test

Under the bill, an employer may elect to forego testing and instead include the employer premium for health coverage as taxable income on the W-2 of highly compensated employees.

Qualification rules

In general

An employer's fringe benefit plans are required to meet certain minimum standards. These standards require that a plan be in writing, employees be notified of plan provisions, the plan be maintained for the exclusive benefit of employees, the plan be legally enforceable, and that the plan is intended to be maintained for an indefinite period of time (the permanence requirement). Under present law, if an employer's plan does not satisfy the qualification requirements, then all employees must include in income the value of benefits (e.g., reimbursements for health care) received under the plan.

The bill replaces the present-law sanction for failure to satisfy the qualification rules with an excise tax on the employer and makes certain modifications to the qualification standards. Under the bill, the qualification rules no longer apply to any plan the benefits under which are excludable under section 132. Thus, the qualification requirements do not apply to no-additional-cost services, qualified employee discounts, or employer-provided eating facilities. As under present law, an employer's failure to meet the qualification requirements does not, in and of itself, create a private right of action on behalf of employees, nor does it create any inference that such a right of action may exist.

As part of the modifications to the sanction for failure to satisfy the qualification rules, the bill removes the rules from section 89 and adds the rules to new Code section 4980C. As is the case generally under the bill, it is intended that legislative history and guidance by the Secretary relating to the qualification rules under present law continue to apply to the rules as modified by the bill, except to the extent inconsistent with the provisions of the bill.

For example, as under present law, a plan generally meets the permanence requirement if the plan provides coverage for a continuous 12-month period. If the plan is in effect for less than 12 months, the employer generally will not violate the permanence requirement upon a showing of a substantial independent business reason for the modification or termination of the plan. Similarly, the notice requirement is met if a third party, such as an insurance company, provides notice to the employees of the plan.

The bill modifies the exclusive benefit requirement. This requirement is not violated merely because nonemployees or other individuals without a service nexus to the employer are covered under the plan on an after-tax basis. As under

present law, the exclusive benefit rule is not intended to override other provisions with respect to who may be covered under a plan (e.g., rules relating to section 125 and section 501(c)(9)).

Sanction for failure to comply

The bill replaces the present-law sanction with an excise tax on the employer. Under the bill, no penalty applies with respect to a failure to satisfy the qualification rules if the employer corrects the failure to comply within 6 months of the date the employer knew or should have known of such failure. If the employer does not correct the failure within this 6-month period, then an excise tax is imposed. The excise tax is equal to 34 percent of the costs paid or incurred by the employer for coverage under the plan that relates to the failure. In the event of a willful failure to comply with the qualification requirements, the tax is imposed from the date of the failure without regard to any subsequent correction. Under the bill, the Secretary is authorized to waive the excise tax in whole or in part if the failure is not due to willful neglect and to the extent the payment of the tax would be excessive relative to the failure involved. In the event the failure relates to a multiemployer plan, the excise tax is imposed on the plan.

Good faith compliance

The Tax Reform Act of 1986 directed the Secretary to issue guidance on certain employee benefit provisions added by the Act, including section 89. Under present law, until the Secretary issues guidance on which taxpayers may rely with respect to such provisions, an employer's compliance with its reasonable interpretation of the provision, based on the statute and its legislative history, if made in good faith, constitutes compliance with the provision. The bill applies this good faith compliance standard to the provisions of the bill. This good faith standard applies, for example, to the rules relating to separate lines of business and the new definition of leased employee under the bill.

The bill also provides that, with respect to lines of business that do not meet the guidance issued by the Secretary, the good faith standard applies to the determination of whether lines of business are separate under section 414(r)(2)(C) until the Secretary begins issuing rulings relating to lines of business.

Except where directly inconsistent with the provisions of the bill, prior legislative history relating to any provision amended by the bill (including the rules of section 89) and guidance issued by the Secretary pursuant to any such provision, continue in effect.

Effective date

The new discrimination rules relating to section 89 are generally effective for plan years beginning in 1990. The employer is permitted an election to use present law with respect to its plans for 1990 and 1991. This election relates to all plans of the employer and may be made on an annual basis. The employer may also elect to use present law to test its dependent care assistance programs under section 89 for 1990 and 1991. Whether or not the employer makes such election, the changes under the bill that relate to part-time employees apply.

C. Repeal of Special Rules Applicable to Financially Troubled Financial Institutions (Code secs. 597, 368(a)(3)(D), and 382(l)(5)(F))

Present Law and Background

Present law

Special tax rules applicable to financially troubled thrift institutions were adopted in 1981. In the Technical and Miscellaneous Revenue Act of 1988 (the "1988 Act"), these special rules were expanded to cover financially troubled banks. These rules are scheduled to expire for transactions after December 31, 1989.

(1) Assistance payments to financially troubled financial institutions

Payments from the Federal Savings and Loan Insurance Corporation (the "FSLIC") or the Federal Deposit Insurance Corporation (the "FDIC") to a financially troubled financial institution are not included in the income of the recipient institution and such institutions need not reduce their basis in property by the amount of such financial assistance. However, the 1988 Act provided for a reduction in certain tax attributes of a financially troubled financial institution equal to 50 percent of the amount of the financial assistance (Code sec. 597).

(2) Treatment as a tax-free reorganization

Certain FSLIC- or FDIC-assisted acquisitions involving a financially troubled financial institution may qualify as tax-free reorganizations, without regard to the requirement for a tax-free reorganization that the shareholders of an acquired corporation must generally maintain a meaningful ownership interest in the acquiring corporation (the "continuity of interest" requirement) (Code sec. 368(a)(3)(D)).

(3) Net operating loss carryovers

The general limitations on the ability of an acquiring corporation to utilize the net operating losses, built-in losses, and excess credits of a corporation acquired in a tax-free reorganization are relaxed in the case of a tax-free acquisition of a financially troubled financial institution (Code sec. 382(l)(5)(F)).

House action on H.R. 1278

Repeal of special tax rules

In connection with the consideration of H.R. 1278, (the Financial Institutions Reform, Recovery and Enforcement Act of 1989), the House Committee on Ways and Means reported out an amendment to repeal the special tax rules applicable to financially troubled financial institutions.[4] The repeal would be effective for transactions occurring on or after May 10, 1989 (the date of Ways and Means Committee action on H.R. 1278).

Under the Ways and Means Committee amendment, the Treasury Department would be granted regulatory authority to issue regulations providing rules for the Federal income tax treatment of transactions involving financially troubled financial institutions. The Treasury Department would be directed to promulgate rules which ensure that taxpayers do not receive duplicative benefits from the combination of tax-free assistance payments together with the deductibility of losses and expenses.

In addition, interim rules contained in the legislative history would specify the Federal income tax treatment of taxable asset acquisitions of financially troubled financial institutions pending issuance of rules by the Treasury Department.

Clarification of 1988 legislation

The Ways and Means Committee amendment would clarify that the reduction in tax attributes equal to 50 percent of the amount of nontaxable financial assistance received with respect to FDIC transactions and certain FSLIC transactions (involving institutions which did not meet a qualifying asset test) is effective on the same date that the special tax rules relating to financially troubled financial institutions were extended to such transactions (i.e., November 10, 1988, the date of enactment of the 1988 Act).

Explanation of the Proposal

The special tax rules applicable to financially troubled financial institutions would be repealed prior to their scheduled expiration date.

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[4] See H. Rept. 101-54, Part 2, May 22, 1989.

D. Extension of the Telephone Excise Tax

Present Law

A 3-percent excise tax is imposed on amounts paid for local telephone service, toll telephone service and teletypewriter exchange service (sec. 4251). The tax is paid by the person who pays for service to the person rendering the service, who in turn remits the tax to the general fund of the Treasury.

Exemptions from the tax are provided for communications services furnished to news services (except local telephone service to news services), international organizations, the American National Red Cross, servicemen in combat zones, nonprofit hospitals and educational organizations, and State and local governments. Other exemptions include amounts paid for installation charges and for certain calls from coin-operated telephones (sec. 4253).

This excise tax is scheduled to terminate, effective with respect to amounts paid pursuant to bills first rendered on or after January 1, 1991.

The 3-percent telephone excise tax was last extended for 3 years (1988-1990) in the Omnibus Budget Reconciliation Act of 1987. The 3-percent tax was previously extended for 2 years (1986-1987) in the Deficit Reduction Act of 1984.

Explanation of Proposal

The 3-percent telephone excise tax would be made permanent. This proposal is included in the Administration's budget proposal.